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EDITORIAL

Too much health care and too little care for the sick?

In the Nordic countries much health care and preventive medicine takes place in general practice. And among general practitioners (GPs) there is an ongoing debate on whether they should devote more or less time to preventive measures and health care. There has been much debate on whether the benefits of preventive health care truly outweigh the costs and the adverse effects. Some GPs fear that demands for health promotion and preventive medicine will make the well profit at the expense of the sick. Some GPs anticipate that one day their waiting rooms will be filled with people waiting for the doctor's advice on how to stay healthy rather than sick patients waiting to be cured.

Warnings have been issued that GPs may end up spending too many of their limited time resources on identifying and treating patients with increased risk of morbidity and mortality [1–3]. GPs would have to spend 7.4 hours per working day to provide all the preventive services recommended by the US Preventive Services Task Force [4]. It seems unlikely that GPs in reality spend that amount of time. A simple Medline search using the search terms “time factors”, “risk interventions”, and “primary health care” did not yield any evidence about how much time is devoted to risk interventions. In a survey among Polish and Danish GPs, 82% and 52% respectively stated that they would like to do more preventive health care [5], and there is evidence that GPs do not fully implement clinical guidelines [6,7].

Worries have been proposed that too much preventive health care actually makes people sick [8]. If the European guidelines on cardiovascular disease prevention were implemented, 76% of the adult population would have “unfavourable” risk profiles [9]. Whether an unfavourable risk profile and being sick are equal is, however, a debatable matter.

“Too much health care and too little care for the ill” will depend on patients' preferences, doctors'

preferences, and the preferences of those who organize and finance primary care. An important issue here is the alternative uses of the time spent on “risk patients”, since healthcare resources are limited, and resources spent on risk identification and reduction cannot be spent elsewhere. Opportunities for providing care and creating health benefits are therefore forgone. Economic evaluation in the form of cost-effectiveness analysis is a tool to guide priority setting in health care. Preventive care does reduce health costs in some cases, but not in all, and maybe not in most. Some risk interventions such as cholesterol lowering are cost-effective in high-risk patients while the same intervention in low-risk patients is probably not [10]. The cost-effectiveness of antihypertensive treatment depends on patient characteristics and the choice of therapy [11]. The cost-effectiveness of risk identification and preventive intervention should therefore be considered in the context of the prevalence of disease, patient characteristics, and test characteristics such as sensitivity and specificity. This accounts for measures taken at the population level as well as at the individual level. In conclusion there seems to be limited evidence that GPs spend too much time on health care and too little time on care for the ill. Prevention is often worth doing because it brings better health. But with prevention, as with treatment, better health comes at a higher price most of the time. Whether preventive health care is better placed in general practice or elsewhere remains to be explored.

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